

# RACE AND SEXUAL IDENTITY: PERCEPTIONS ABOUT MEDICAL CULTURE AND HEALTHCARE AMONG BLACK MEN WHO HAVE SEX WITH MEN

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Black men who have sex with men (BMSM) in the United States are disproportionately affected by HIV. Using a qualitative approach, the authors describe the healthcare experiences of BMSM in New York State and Atlanta, GA, exploring the social issues that influence barriers to care, communication, and adherence in medical settings.

Racial and sexual discrimination socially displace BMSM, and are often compounded by negative encounters within medical institutions. The internalization of these experiences influences healthcare utilization, HIV testing, communication, and adherence behaviors among members of this population. Increasing the number of ethnic and sexual minority providers, expanding current definitions of cultural competency curricula at academic institutions, targeting future research efforts on BMSM, and improving the structural and communication barriers within healthcare settings should be incorporated into our HIV prevention and routine healthcare interventions for BMSM. (*J Natl Med Assoc.* 2004;96:97-107.)

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## BACKGROUND

It is estimated that 1 of every 50 African-American males is infected with HIV.<sup>1</sup> For black men who have sex with men (BMSM), the prevalence estimates are 33% for 15–29-year-old BMSM in some major metropolitan cities.<sup>2</sup> Up to 93% of these men are unaware of their HIV status, which may influence severity of disease at diagnosis for BMSM, as well as overall morbidity and mortality rates.<sup>3</sup>

While a number of individual, behavioral, and knowledge-based variables may explain part of this disparity, little is known about the role that BMSM's healthcare experiences play in this epidemic.<sup>4-8</sup> Physician-negative perceptions of African Americans as less educated, less intelligent, and less pleas-

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ant influence their expectations of these patients to engage in risk behavior and follow medical advice.<sup>9</sup>

<sup>10</sup> Physicians' prediction that African-American men are less likely to adhere to highly active antiretroviral therapy (HAART) influences their treatment decisions, including rates of prescribing prophylactic medications for opportunistic infections.<sup>11</sup> Moreover, HIV-positive black men's perceptions of physician competence and support may influence their adherence to protease inhibitors.<sup>12</sup>

Communication, trust, and issues of support in the doctor-patient relationship are important variables influencing medical utilization and adherence among African Americans, particularly when perceived race-based discrimination exists.<sup>13-17</sup> African Americans with HIV/AIDS utilize fewer outpatient and more inpatient care than their white counterparts, even when controlling for insurance and socioeconomic status.<sup>18-19</sup> This heavy reliance on inpatient and emergency room (ER) facilities leads to worse HIV health outcomes, while increased outpatient support and ancillary services lead to improved adherence, increased clinic retention rates, and decreased hospital admission rates.<sup>20-24</sup>

Little is known regarding the qualitative relationship between the healthcare experiences of BMSM and their utilization behaviors. Given the unique social circumstance of being both black and homosexual, and the current HIV disparity in this population, the specific aims of this study were to qualitatively describe the: 1) healthcare experiences of BMSM; 2) perceived influence of their race and sexuality on these experiences; 3) perceived barriers to healthcare utilization; 4) quality of doctor-patient communication; and 5) factors affecting adherence in this population.

## METHODS

### Participants

Eight focus groups were conducted between December 2000 and February 2001 in New York State. An initial pilot focus group was conducted with five participants in Atlanta, GA, and the remaining focus groups took place in central Manhattan, Harlem, Brooklyn, Albany, Rochester, and Buffalo. Participants (n=81) were recruited through a collaboration between the New York City Department of Health Preventive Medicine Residency Program, the Mailman School of Public Health at Columbia University, and the New York

State Black Gay Network (NYSBGN). The NYSBGN is a coalition that links community-based organizations (CBO) and service providers in New York State that target BMSM for HIV prevention and other services. The locations for the New York focus groups were selected based on CBO affiliations with the NYSBGN. The Atlanta focus group was recruited through a local BMSM support group called Second Sunday.

Inclusion criteria for this study included: 1) being a man of African descent; 2) being over 18 years of age; 3) English speaking; and 4) identifying as a man who has sex with other men. The lead author worked with the executive directors of CBOs in each city on participant recruitment methods, including: 1) email announcements to CBO clients; 2) verbal announcements during routine meetings of CBO clients; 3) mailed flyer notifications to CBO clients; 4) word of mouth. The executive director of each organization screened prospective participants for inclusion criteria and gave them information regarding the nature of the study, compensation, location, and contact information. Interested participants signed up either in person or over the phone, and the executive directors and principal investigator communicated weekly to update the list of study subjects. Each focus group was limited to 12 participants.

### Procedure

The focus groups were conducted in private rooms at the CBO of each respective city. Participants were given an IRB-approved information form that explained the study, with contact information of the investigators for future questions. Each session lasted 90-120 minutes, and participants were given refreshments and \$25.00 compensation. They were not asked to identify themselves in any way. Two facilitators were present at each focus group and were self-identified BMSM who were familiar with issues in the community. The principal investigator, present as a facilitator for all of the focus groups, was identified as a medical doctor on the information form but not verbally during the discussion unless asked. The focus group discussions consisted of several open-ended questions with optional probes, based on the specific aims of the study (Table 1). Each session was transcribed by an outside agency and reviewed by the principal investigator for accuracy.

## Analysis

The principal investigator reviewed each focus group transcription with its corresponding audio-tape to ensure accuracy of contents. The first two authors reviewed the content of each focus group transcript separately. Themes emerged regarding the variables influencing healthcare access, communication and utilization behaviors, and the authors met regularly in an iterative process to review the themes agreed upon by the first two authors. Coding, data entry, and associations of the interview transcripts were organized using Atlas TI software, with subsequent analysis performed by the authors. Reliability was achieved through consensus among the authors on relevant themes and codes in the transcripts.

## RESULTS

Participants were almost equally divided between New York City and upstate New York discussion groups (49% versus 44%), with the remaining participants comprising the Atlanta group. They were also equally divided in terms of identifying their sexual orientation as “gay” (53%) versus other identification categories (homosexual, bisexual, same-gender-loving, two-spirited: 47%), and regarding HIV status: HIV positive (48%), HIV negative (47%), with 5% reporting their status as “unknown.” The demographic profiles of the participants can be found in Table 2.

## Adaptation to Racial and Sexual Prejudice

The theme of racial identification as black men was an irrefutable reality and viewed as the primary identity targeted for discrimination by the outside world (location and age of participants in parentheses):

“Being a black man is a hard struggle. Not just being gay, being straight—being a general black man is an everyday struggle. I don’t care how you put it, white America either wants me in a cell or in a grave.” (Rochester, 21)

“We [black men] have to wake up in the morning and put on armor every day.” (Rochester, 20)

“Because we’re black, we all have the same face, so to speak. So when you approach somebody, they think that you’re going to automatically cross them in a very aggressive, intimidating way. You’re black first. (Atlanta, 33)

“For me, whether it’s sexuality or just gender,

it’s always gonna be an issue of race. I’m gonna be seen as a black man.” (Albany, 42)

The words used to describe their racial awareness reflected perceptions of the world viewing them as aggressive black-male stereotypes, and day-to-day existence as a battle or struggle. Additionally, displacement from family, church, and the black and gay white communities for how they

**Table 1. Focus Group Moderator Guide**

### QUESTIONS

*Experiences with healthcare providers  
(10 minutes)*

Tell me the first words or images that come to your mind when you hear the word “doctor.”

*Normative Influences (10 minutes)*

What were/are your family’s attitudes and beliefs about medical providers and healthcare?

*Barriers to healthcare (10 minutes)*

What makes it difficult for you to see a medical provider?

*Perception of reception (20 minutes)*

Tell me about your last experience seeing a medical provider.

*Race/sexuality issues and medical providers  
(20 minutes)*

As black men who have sex with men, what role does race and sexuality play in your interactions with medical providers?

*Adherence issues and medical providers  
(10 minutes)*

Tell me what factors contribute to you following or not following a medical provider’s recommendations (such as getting blood tests, taking medications, etc.).

*Communication and medical providers  
(20 minutes)*

Tell me about the communication between you and medical providers.

*Future relations between AAMSM and medical providers (10 minutes)*

When I go back to the medical profession to report on this focus group, what do you want me to tell them?

existed as homosexuals played an important role in everyday life:

"I think the biggest betrayal that I faced is the one that comes from my own family. The fact that most of the people in my immediate family have religious beliefs that are contrary to the [homosexual] lifestyle I live." (Albany, 36)

"The experience that took me away from doctors was with the church. I thought I had a doctor that was cool. He invited me to a special church service. We get there, the topic, 'Homosexuals: Should we pin 'em up in an alley, or should God destroy them?' And I fell apart because I was so hurt." (Brooklyn, 30)

"Some people in the gay community, they can be real vicious, especially if you ain't comfortable with your 'gayness.' And you go into a bar or hang out with somebody, and they cut you up. You so far in the closet, it's gonna take a search team to find you." (Buffalo, 28)

"I mean, you get this big old turn off, they [the black community] lights go out once your sexuality comes out. So when the lights go out, you go out. You don't say nothing about your sexuality because you don't want that. You look to these people for support, for love, for guidance, and once your sexuality comes out, it changes." (Rochester, 20)

The sense of disconnect from mainstream white culture combined with social isolation from the black community for being homosexual displaced some BMSM from any real sense of community belonging. In order to achieve a sense of "belonging", adapting to the climate of different social communities was a coping mechanism utilized to fit in, although not without its price:

"Bottom line, I was a chameleon. I knew how to get with the drug people, I knew how to hang with the white people, I knew how to hang with the gay people, I knew how to hang with the Baptist folks. Wherever I needed to fit in, I fit in." (Rochester, 40)

"To certain people, at certain points in their life, they don't even know who they are because they keep putting on all these armors, all these different characters. You put on all these armors to the point where you ask yourself, you stop. You ask yourself, 'Who am I?' I mean, you get lost." (Rochester, 21)

Efforts to fit in with different communities, wearing different masks during varying social situations, could leave one with a disjointed sense of

self and still without a sense of truly belonging to any one of these communities.

## Displacement and Medical Expectations

Expectations of medical providers were often influenced by the social context of racial and sexual displacement that BMSM experienced in their daily lives:

"When I go into a physician's office, and when I identify myself as a gay person, part of that is looking for acceptance from them, because I haven't gotten it from my family, you know?" (Albany, 42)

"As you take a car to a mechanic to fix it and you want a good mechanic working on your car. That's all I want from going to a doctor. Fix whatever ails me. And be capable of doing that." (Manhattan, 31)

"A doctor deals with people from all walks of life. So you expect them to be understanding and professional." (Harlem, 28)

"I need a doctor that's not gonna judge my sexual preference, because you're dealing with it all the time. And the last thing you need is somebody to judge you when you're sick and at your worst ... to preach to you about your sexual preference." (Albany, 25)

Experiences of prejudice and discrimination appeared to foster feelings of attachment or detachment from medical experiences: Utilize medical services and set high expectations of objective, nonjudgmental, and personal care, or expect discriminatory treatment and relegate the medical interaction to merely "fix whatever ails me." Either way, it was apparent that the social context from which these men emerged had an impact on their approach to their medical experiences.

## External Barriers to Medical Care

Money, acquiring insurance, perceived lack of confidentiality, and an impersonal medical system were themes related to common external barriers to healthcare:

"What I've realized is you have to have money. That's been my goal, to get a job with insurance. Because if you don't have insurance, it's like you don't exist." (Manhattan, 29)

"You can't afford to take that day's pay off to see a doctor, sit in the office for three or four hours, and lose that pay." (Buffalo, 35)

"You go into a health clinic, you went there Tuesday, you're going back Friday to pick up a prescription, your file's been sitting on the table for a whole week. So the cleaner's done seen it, another doctor, little gossiping girl that's on the phone done seen your file, and that's what we're dealing with when we go into these little clinics." (Manhattan, 22)

"And after you've gone from one person to another person to another person...you feel like an object as opposed to a patient or a person. It's a demoralizing process, and it tends to go deep over a period of time." (Atlanta, 35)

These barriers are the ones typically mentioned in accessing health services and were confirmed during the focus groups, with the addition of a medical system that treats patients as "just another number" (as one participant put it) and improperly handles confidential information. Here, external barriers are not only those that prevent one from geographically getting to a medical facility but also those within the institutions themselves that prevent efficient and quality care.

### Internalized Barriers to Healthcare

While external barriers were present, internalized impediments to medical care access, communication, and adherence also emerged during the focus groups, rooted in distrust of the medical system, fear of the health risks of being both black *and* homosexual, and perceiving healthcare as synonymous with "bad news" or judgement and discrimination.

"I see doctors as opportunists. They're like legal hustlers. Just legal drug dealers." (Rochester, 21)

"The same way you look at your shoes [right with left] is how they [doctors] look at gays. Gays is AIDS. AIDS is a monkey. In the dark understanding of the virus, that's where it came from—monkeys. And the monkeys represent what? Blacks." (Brooklyn, 45)

"We have a mistrust to begin with. I think when I first walk in the door, they're going to give me a bunch of pills—I'm not a pill-taker. Or they're gonna give me a shot—I don't like needles. I come into the hospital with an attitude." (Buffalo, 28)

"As being a young black male, if I would come and say something's wrong with me, they [medical providers] would say, 'Oh, look at this, you know, they probably just hip-hoppin' and screwin' down, and you know, smokin' the blunts, and then he gonna come in here, talkin' bout he sick.' So it's

**Table 2. Demographic Characteristics of Focus Group Participants**

Variable	Number	%
<i>Age</i>		
18–29	16	20.8
30–44	52	67.5
45–60	9	11.7
<b>Total</b>	77	100.0
<i>Location</i>		
New York City**	40	49.4
Upstate New York	36	44.4
Atlanta	5	6.2
<b>Total</b>	81	100.0
<i>Sexual Orientation</i>		
Gay	43	53.1
Bisexual	10	12.3
Homosexual	10	12.3
Same-gender-loving	10	12.3
Other (Two-spirited, Transgendered)	7	9.8
<b>Total</b>	81	99.8*
<i>Education</i>		
High school/GED	20	24.7
Some college	28	34.6
College degree	12	14.8
Graduate degree	6	7.4
Job training/other	15	18.5
<b>Total</b>	81	100.0
<i>Employment Status</i>		
Employed	54	68.4
Unemployed	25	31.6
<b>Total</b>	79	100.0
<i>Income</i>		
Less than \$15,000/year	31	41.9
\$15,000–\$30,000/year	20	27.0
\$30,000–\$45,000/year	14	18.9
Greater than \$45,000/year	9	12.2
<b>Total</b>	74	100.0
<i>HIV Status</i>		
HIV negative	39	48.1
HIV positive	38	46.9
Unknown	4	4.9
<b>Total</b>	81	99.9

\*=Percent does not add up to 100.0 due to rounding

\*\*=New York City focus group participants included two New Jersey residents

like I'm stereotyped already. And now, if you say you're gay, everybody can get the picture of the feminine, gay brother. So I guess it can come to sexuality because they [medical providers] feel, 'Oh, he must have been loose in the booty already.'" (Harlem, 19)

"When I was growing up, all I can remember about going to the hospital or going to the doctor was bad news—something terrible." (Albany, 40)

"I think that since my involvement with men, my fear of doctors has just skyrocketed. I can't just be 'sick' anymore. I can't just have a common cold. Everything has to be HIV." (Albany, 36)

Issues around distrust, racial and sexual orientation stigma, and fear of medical facilities can serve as barriers to accessing services and open communication, even when these institutions are geographically and financially within reach. For some, it was a natural extension of everyday life to not talk openly about homosexuality in the medical setting, and it was easier to simply access emergency rooms for medical care on an as-needed basis, which was viewed as a much more streamlined, efficient process than outpatient medicine:

"In school, you got peer pressure. Everything—a lot of it—revolves around sexuality. 'Oh, he dress gay! Oh, he talk gay! Oh, he look gay!' So when you go to the doctor, and he asks you, 'Have you had sexual...' 'No!' I mean, that's just how you look at it, because this big ol' thing about gayness, it's just no. Just no, no, no." (Harlem, 19)

"I would rather go to the emergency room than go to my doctor's office, because I know there I'm seeing the receptionist, the nurse, the doctor, and that's all." (Atlanta, 32)

## Medical Miscommunication

The quality of verbal communication with all levels of medical personnel was also an important component of the overall healthcare experience, influencing not only choice of clinic but also honest communication, adherence, and satisfaction with care:

"I called the office and his receptionist—actually she's half the reason I chose him—because she has this wonderful voice. And she started talking on the phone, and I wanted to go just so I could listen to her talk. She was so warm and reassuring..." (Atlanta, 35)

"And then, I had a few of them [doctors] actual-

ly tell me, 'Well, if you stop the homosexual sex, you could live longer.'" (Brooklyn, 35)

"My doctor—now, I wouldn't say she's uncaring, but she's not that caring either. She's like, 'I wanna put you on medication.' And I'm like 'Why? My viral load is undetectable, and my T-cell count is in the 700s.' And I'm like, 'No!' She says, 'Well, that's the way you wanna go, fine. But it's your life, and if you die quicker because of it then don't come crying to me.' And she filled out a medical form for me and said, 'Refuses to take medications' in big letters!" (Brooklyn, 30)

"She [the nurse] wouldn't tell me what she was doing. She starts thumping here and there, and I have a history of a vein problems. I know where the veins are that I have that work. So she's just poking and poking everything. And I'm—do you want me—are you taking out blood?' Just didn't say—well, it turns out she wasn't taking out blood, she was finding a place to insert to give me an IV." (Albany, 60)

"I have a good rapport with my doctor. We talk, and I tell him everything." (Brooklyn, 30)

"I was talking to her [the doctor] about the symptoms I was having. And she asked me when the last time I had anal sex? And I told her, like, whenever it was. And she's like, 'Well, you know, the anus really isn't made for that.'" (Manhattan, 33)

"And when you see her [the medical provider], it's damn near like seein' your mama, you know what I mean? She goes through all the motions, she chats with you, she laughs with you. She tells you everything. She's just a lovely, bright person." (Brooklyn, 25)

"With the heterosexual male patients that my doctors have, I hear them talking about girlfriends and what not. We don't have that relationship. He don't talk about what I do, or what my dates are. Its always come in, breathe in, breathe out, and out the door." (Atlanta, 30)

According to one participant, communication with medical personnel was like interacting with another culture altogether:

"I think a lot of times it's just a culture. And a lot of these people [doctors] might be knowledgeable, but they're not knowledgeable of the people they're dealing with. So they're generally mechanical. They know how to do this, they know how to do that, but they don't know how to deal with you. They don't know." (Buffalo, 33)

Whether perceived as bad or good, it was obvious that the quality and level of interpersonal communication in the doctor–patient relationship was an important aspect of their overall medical experience.

## Provider Preferences and Cultural Competence

The importance of a personal connection with medical providers was also seen as an important component of the doctor–patient relationship, specifically with regards to race, gender, and sexual orientation:

“Black male doctors, because I am a black male, have always been easier for me to relate to. My doctor now says, ‘What have you been eatin’?’ And I say ‘McDonalds.’ He says, ‘Brother, you need to cut that out.’ You know, they get real with you.” (Atlanta, 33)

“I think part of that is where I come from. I’m from Detroit—it’s a very black city. I’ve always had black doctors. I’ve never in my life gone to a white doctor, or one that was not black.” (Atlanta, 35)

“If you’re not gay, or you’re not black, then you don’t need to be my doctor. I have to be able to relate somehow because a doctor is somebody that’s important in your life.” (Brooklyn, 27)

“I just feel more comfortable talking to a man. I’m a man. I feel more comfortable talking to a man about my parts and all that, because he has the same parts.” (Buffalo, 40)

“We don’t have enough people of color in the medical field. We need more of us out there. And so they have to sympathize, because if I wanna talk about collard greens, and somebody stayed in the suburbs, they don’t know anything about collard greens. They have no understanding so I can’t communicate—because you have to have that communication to deal with the doctor so he can know where you’re coming from, you know?” (Buffalo, 32)

Black culture was something that several participants desired their medical providers to understand, and black medical providers were requested because of the perception that they could relate on a more personal level than providers of other ethnicities. Additionally, the issue of cultural competence emerged with regards to perceived negative experiences with foreign-born medical doctors, which had an impact on the medical experience:

“You know, racially, I’ve seen some [foreign doctors] interact with white patients in a more per-

sonable, more sociable...but when it comes to black patients, some of them are like, ‘whatever,’ and they’ll just do this and do that.” (Atlanta, 33)

“With Asian doctors, there’s a language barrier there. They don’t understand what you’re saying, you might not understand what they’re saying. But for black doctors, they’ve had to bust their butt harder to get where they’re at.” (Manhattan, 28)

“There are times—rather than have a foreign doctor or healthcare provider—I will walk out and do without.” (Manhattan, 60)

“Just everyone who’s not black, to me, really—they just don’t understand too much about my culture.” (Harlem, 35)

Regardless of specific gender, race, and sexual orientation preferences for their doctors, feeling an individual connection with a medical provider was a central theme for the BMSM in this study, underscoring that doctors be trained to communicate effectively with *all* patients culturally “foreign” to them, not just the patients born outside the United States.

## Investing in One’s Health

Investment in one’s health is a dynamic choice influenced by all the personal, social, and institutional variables that make up the medical “experience.” As one participant stated:

“Make me feel that it’s a positive enough process that I will work towards doing my part in it. Because if I’ve been turned off, then I don’t wanna hear anything, and I will probably act in a manner that’s not in my own self-interest, because I’ve just been turned off by the whole experience. Whereas if I feel that someone else cares, that’s the kind of like encouragement for me to really invest in myself better.” (Manhattan, 60)

The amount of investment one makes in his health may, in part, be a reflection of how much he perceives his provider accepts and invests in him *as he is*. This notion is magnified for BMSM, where the unique experiences with racial and sexual prejudice that lead to displacement and social isolation may make the medical encounter a more crucial place for effective social and medical interventions than for other populations.

## DISCUSSION

The findings from this study suggest that the internalization of oppressive social conditions can

influence the healthcare experiences of BMSM. Despite recent debate over its role as an independent scientific health predictor, race and experiences of racism cannot be ignored when discussing sexuality in the medical setting.<sup>25-27</sup> Experiences with societal and institutional racism, and the subsequent expectation of medical racism, impacts how open BMSM are with providers about their sexuality due to fear of additional discrimination. Additionally, feelings of detachment from white society (including “gay” culture) as black men and from the black community for being homosexual may foster a sense of psychological displacement that influences their expectations of, and interactions with, medical personnel. This internalized displacement makes healthcare access difficult because BMSM do not feel comfortable within medical facilities themselves, not simply because of geographical, transportation, financial or insurance barriers.<sup>28</sup>

Expectations of medical providers were based on a complex mix of past experiences, community opinions, and idealized notions. Providers were seen as educated potential friends or extended family members, or relegated to mere personnel in an impersonal healthcare system, like a mechanic in an auto shop. While the former expectation is consistent with research findings that African Americans emphasize issues of support and comfort in doctor–patient relationships,<sup>13-17</sup> the latter expectation emphasizes potential reactions to personal displacement among BMSM because of their dual marginal status as both black and homosexual. If interactions with medical personnel were simply a mirror of prejudicial social experiences, behaviors, such as not utilizing services, overemphasizing ER facilities, or not telling the truth about risky sexual practices, could be seen as reactions to unmet or confirmed expectations. While these dynamics do not directly influence the sexual behaviors of BMSM, they limit the extent to which medical facilities can effectively address HIV in this population, HIV testing practices, and also may help explain why 93% of HIV-infected BMSM in select cities do not know their HIV status.

Barriers to healthcare utilization for BMSM in this study included *external* problems of insurance; questionable confidentiality; multiple personnel; a rushed impersonal atmosphere and noncommunicative staff; as well as *internalized* barriers of medical distrust and fear of both sickness and discrimination based on being a member of a risk

group for HIV. Increasing HIV education outreach efforts, establishing more local clinics, and providing universal health insurance will not sufficiently address these barriers. Improving the healthcare utilization and adherence patterns of BMSM must occur in three areas: 1) enhancing existing cultural competency curricula; 2) recognizing the important role of minority providers; and 3) increasing research efforts on BMSM.

Current cultural competency curricula in medical education programs must be expanded to include all medical personnel, as brief interactions with staff other than medical providers can impact the overall healthcare experience of the patient. Additionally, these programs should equally stress training foreign health professionals about considering the diverse racial and cultural backgrounds of American patients, just as we train American doctors to consider the cultural backgrounds of our varied foreign-born patients. While participants’ responses on negative experiences with culturally “foreign” doctors may be viewed as isolated events, they nonetheless emphasize that the fact that medical cultural competency is a two-way street and can have a significant impact on healthcare utilization and communication practices.

Improved medical training in sexuality and sexual history-taking is needed, which acknowledges the varied cultural expressions of sexuality among different populations. Teaching healthcare-professional students to screen for HIV risk by targeting risk groups like “BMSM, straight, or gay, in essence, tells a patient they are at risk for HIV because of who they are and may make them fearful to engage medical facilities for fear of diagnosis just based on their personal demographic profile. This, may, in turn, perpetuate fear-based miscommunication of risky sexual behaviors, avoidance of testing services, and access to prevention materials among the very population it is designed to target. Instead, providers-in-training should be instructed to screen patients according to HIV *risk behaviors* (unprotected anal sex, vaginal sex, oral sex), which will avoid stigmatizing individuals based on risk groups, while enhancing HIV screening of those who are behaviorally putting themselves at risk despite not belonging to traditional risk groups.

While discussing potential solutions to the external barriers to healthcare may be beyond the scope of this article, addressing the problem of



internalized barriers to care among BMSM must start with acknowledging the need for more minority providers in minority communities. Finding a cultural connection with a provider is an important component of the doctor–patient relationship, and the need for black and/or homosexual patients to see physicians with whom they feel a cultural connection was emphasized by findings in this study. Continued active recruitment of minority applicants to medical schools and encouraging future service in minority communities among current minority medical students and residents can make a huge difference in our patients' healthcare experiences. The larger issues of racial and sexual prejudice that BMSM face outside and within the black community are key here: If BMSM are feeling displaced from the mainstream white, gay white, and general black communities, black medical providers can play a pivotal role in not only combating this sense of displacement during the outpatient encounter but also by individually empowering BMSM to become more invested in their own healthcare, particularly with regards to HIV. Additionally, black medical providers can become more involved in research, policy, and collaborative efforts with black community and faith-based organizations that can begin to discuss and address the roots of the social isolation felt by many BMSM in their everyday lives.

Finally, more research is needed to examine the factors influencing health outcomes in this population. Specifically, minority researchers who are familiar with the cultural issues impacting the black community and willing to ask the difficult questions and explore the complex social dynamics that shape the healthcare experiences for diverse sexual people of African descent are needed. Despite the alarming HIV prevalence among BMSM, few studies have explored the complex role that medical culture plays in this epidemic. Additional qualitative studies are warranted based on this study's findings, and pursuing quantitative research with representative sampling can further assess the relationship between personal variables (age, geography, HIV status, sexual identity, provider characteristics) and the healthcare utilization, communication and adherence practices of BMSM.

There are several limitations to this study. We described the nature of the healthcare experiences and utilization practices of BMSM but cannot determine causal relationships that influence

healthcare utilization, adherence, and HIV testing. Moreover, reliance on a small convenience sample and lack of an experimental design limits the internal and external validity of the data. Specifically, all participants were recruited through black CBOs who did HIV prevention work, resulting in an oversampling of BMSM who were comfortable enough with their homosexuality to access these services and participate in this study. Likewise, geographical and individual (HIV status, age, SES) subanalyses were difficult to perform, as subject diversity within the focus groups made it difficult to make generalized group conclusions based on individual comments that could not be traced back to certain demographic characteristics. Specifically, we could not adequately explore differences between HIV-positive and HIV-negative BMSM in these groups, as not all men openly discussed their HIV status within the group, and the focus groups had individuals of mixed serostatus. One-on-one interviews or recruitment of seroconcordant focus groups would be more suitable methodologies for efficient exploration of these differences. Additionally, the presence of a medical doctor as one of the facilitators is also a potential bias.

Ultimately, qualitative research discusses the meaning behind relevant themes emerging from research questions. We did not include quantitative assessments of how many participants expressed a certain theme—as a theme mentioned—even once, is a relevant finding. The themes included in this manuscript, however, reflect the most common that emerged during our discussions across all the geographical regions and are evidenced by the diversity in sources of quotes in the Results section. Despite these limitations, our findings effectively describe the nature of healthcare experiences for BMSM and are useful for future pilot interventions and the identification of additional barriers to healthcare for subsequent quantitative studies.

The results from this qualitative study have important implications for public health and medical responses to the HIV epidemic among BMSM. While BMSM may lack knowledge of their serostatus and underestimate their HIV risk, institutional and internalized barriers experienced by these men may negatively impact healthcare utilization behaviors, communication, and adherence that could influence this ignorance and underestimation of risk. As underutilization of outpatient HIV services leads to poorer health outcomes

among African Americans in general, it is apparent that specific HIV prevention and treatment initiatives for BMSM must focus on improving the quality of outpatient medical experiences that are currently available for these men.<sup>20-24</sup>

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